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United States Nuclear Regulatory Commission
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Subject: Response to Inspection Report 89022

Gentlemen:

Toledo Edison (TE) has received Inspection Report 89022 (Log Number 1-2198), and provides the following response. The due date for this response was extended to January 22, 1990 per discussion with the Senior Resident Inspector on January 11, 1990.

Violation

89022-04: "10CFR50.59(b)(1) requires the licensee to maintain records of changes in the facility as described in the safety evaluation. The Updated Safety Analysis Report (USAR) describes door 212 between rooms 235 and 227 as being capable of withstanding the hydrostatic pressure resulting from a flood level in room 235 of 3.5 feet and requires the door to be shut. The flooding of room 235 could result from a ruptured Auxiliary Feedwater (AFW) pipe located in the room. Safety-related electric motor control centers (MCC's) located in room 227 could be adversely affected by flooding with door 212 in the blocked open position.

Contrary to the above, on November 1, 1989, and on several previous dates, the inspectors observed door 212 to be blocked open thus preventing it from performing its flood protection function, and potentially affecting safety related MCC's located in room 227. The licensee did not perform a safety evaluation to describe this change in the facility as required by 10CFR50.59."

Response: Acceptance or Denial of the Alleged Violation

Toledo Edison acknowledges the occurrence of a violation with the clarifications provided below.

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Reason for the Violation

As described in Violation 89022-04, door 212 must be closed to mitigate the consequences of flooding from an Auxiliary Feedwater (AFW) discharge line break in room 235. USAR Section 3.6.2.7.1.8 states that the design basis line break would result from critical cracks which are only postulated to occur during long term usage (after 24 hours) of the AFW system subsequent to actions necessary for safe shutdown.

Previous controls for maintaining the specified position of the door consisted of a sign on the door which required that the door remain closed except for normal entry and exit or when the room was manned. The sign did not list a requirement to notify the Shift Supervisor if the door was to be blocked open. This notification is necessary to ensure that appropriate considerations have been adequately addressed. The current philosophy for addressing a situation involving a door designated for flooding, fire protection, high energy line break (HELB), or a negative pressure boundary requires that an evaluation be performed if the door is to remain open for purposes other than normal access. The operability evaluation includes applicable Technical Specification and USAR considerations. Due to a personnel error this evaluation was not performed prior to blocking door 212 open.

Since the door being in a position which deviated from the USAR requirements was the result of a personnel error Toledo Edison recognizes this occurrence as a violation of administrative requirements rather than a violation of 10CFR50.59. Current 10CFR50.59 guidance does not require a safety evaluation for identified deviations which are subsequently restored to a previously analyzed condition.

An evaluation of door 212 was performed subsequent to the door being identified as a blocked open flood door. Door 212 was closed at that time. The evaluation and root cause for the identified USAR deviation were documented in Potential Condition Adverse to Quality Report (PCAQR) 89-575. The evaluation determined that the only time the AFW pump discharge line would be pressurized, and therefore pose a potential high energy hazard, is during accident conditions that demand initiation of AFW. Postulating an additional accident initiator, such as a high energy line break (HELB) during an accident is not required. Other potential sources of flooding would not be safety significant because the resulting volume is within the capability of the floor drains and sumps of the affected areas and a loss of vital functions would not be anticipated.

The existing analysis for a HELB in room 235 on the Main Steam supply line to the AFP turbine 1-1 conservatively assumed that door 212 was open. Because a break of this line bounds other potential breaks in room 235, there is no safety concern with door 212 being open.

PCAQR 89-575 was attributed to personnel error since the controls which existed previously should have prevented the identified deviation. The absence of a requirement to notify the Shift Supervisor when the door was open was considered to be a contributing factor.

Corrective Action Taken and Results Achieved

As previously stated, door 212 was closed after identification by the resident inspector and an evaluation was subsequently performed.

Actions to Prevent Recurrence

The sign for door 212 will be changed to include a requirement for notifying the Shift Supervisor. The remaining doors will be reviewed to determine the adequacy of the existing signs for the doors.

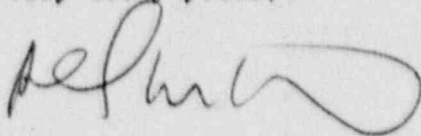
Additionally, a memorandum (NEN-89-10390), dated December 22, 1989, was issued to provide guidance to operations personnel for determining barrier door operability requirements. The guidance memorandum augments a previous memorandum (ISE 87-10014) issued in 1987 which provides a matrix listing of safety-related doors and various functions of each safety related door. This information will be reviewed for accuracy and transferred to a controlled drawing for general use. This information is currently utilized on a discretionary basis. Specific guidance concerning door operability determination will be incorporated into the appropriate Operations procedures once the door listing becomes controlled.

Date When Full Compliance Will Be Achieved

Full compliance with the corrective actions listed above is scheduled to be completed by April 30, 1990.

If you have any question regarding this matter, please contact Mr. R. W. Schrauder, Manager - Nuclear Licensing, at (419) 249-2366.

Very truly yours,



RWG/ssg

cc: P. M. Byron, DB-1 NRC Senior Resident Inspector
A. B. Davis, Regional Administrator, NRC Region III
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